Final Report of the New Brunswick Roundtable on Maternity and Newborn Care

November 4, 2005
Fredericton, NB

Full Report

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ACKNOWLEDGMENTS

First, thanks to all of the women who shared their births stories with us.

Second, thanks to all the participants who were able to take time out of their busy schedules and lives to attend and enrich the discussion with their myriad of experiences and backgrounds. In addition to thanking all of the participants who were able to attend the roundtable, I wanted to also thank and recognize the dedication to these issues from everyone else who expressed interest, but were not able to attend.

Thanks to Sue Calhoun (Calhoun Research & Development) for facilitating the discussion and her note taker (Raphaëlle) for capturing that discussion.

Thanks to Kate Nicholls and the members of Birth Matters for all their help in preparation for the roundtable.

Last, but not least, thanks to Norma Dubé and colleagues at the Women's Issues Branch for her assistance, valuable advice and guidance throughout -as well as for the food!

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Introduction

The roundtable began with introductory comments by Christine Saulnier of the Atlantic Centre of Excellence for Women's Health, Kate Nicholl from Birth Matters and Norma Dubé, from Women's Issues Branch of the government of New Brunswick. The introductory comments emphasized the need to recognize the complexity of the issues we will be discussing regarding maternity care services. Everyone was reminded that they were all there for the same reason: to begin a dialogue about how to improve the maternity care experience of women and their families in New Brunswick. To enter into this dialogue, everyone also needed to understand what the situation is today. We know that providers need to be better supported in their work and perhaps supported to work in new ways. We also know that we can better utilize the research and evidence that we have, as well as recognize the need to do more research and use it to improve care. What we need to do is what the current situation means for women receiving care. The goodwill of just being at the roundtable was recognized and highlighted as a first step in building needed partnerships in order to move this work forward. The hope for the organizers was that the roundtable would be a place to figure out what our common interests and values are and how these can inform some concrete next steps.

Roundtable Background

The New Brunswick Roundtable on Maternity and Newborn Care was co-hosted by the Atlantic Centre of Excellence for Women's Health, with Birth Matters, in partnership with the Women's Issues Branch, Government of New Brunswick. The purpose of the roundtable was to discuss the status of maternity and newborn care in New Brunswick. In the interest of exchanging ideas and developing strategies for ensuring that women in New Brunswick receive the most optimal primary maternity care possible, this roundtable aimed to bring together policy makers, health care providers, programme planners, administrators, community activists, and consumers to discuss what is working and what needs to be improved. The following questions guided this roundtable:

1. What maternity and newborn care options are available?
2. How has New Brunswick integrated the National Guidelines for Family-Centred and Newborn Care? How could New Brunswick further ensure that care provided during pregnancy, labour and birth, as well as early postpartum care of the mother and infant, adhere more closely to these guidelines?
3. What current health human resource issues affect the status of this care in the province? How might we ensure that maternity and newborn care services are provided to women by the most appropriate health care provider? Other regions of Canada have integrated midwives as integral primary maternity caregivers in the health care system. How might the inclusion of midwives and doulas improve the situation?

Roundtable Participants

The participants were drawn from a range of sectors including academic, government and community. A list of the attendees to the roundtable as well as the full list of invitees is included.

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The participants, however, also included all the consumers who were not actually at the roundtable but who had submitted birth stories as a way to have their voices incorporated into the roundtable discussion and subsequent record of the state of maternity and newborn care in New Brunswick. These stories were not collected in a way that would ensure a representative sample of birthing women in New Brunswick. Many of these stories came from women who responded to the call for stories via the New Brunswick Advisory Council on the Status of Women's list serve.

We know that each and every birth story is very powerful and can having a lasting impact on the women who have experienced them as well as on expectant mothers who hear or read them. These stories influence and are influenced by the birth culture - that is the way we learn about, talk about, feel and experience birth. As one birth mother said in her birth story: *"A woman will carry her birth experiences around with her for the rest of her life. She'll tell the stories over and over again and they'll influence the type of mother she becomes and the way she feels about herself."* In addition to the birth mothers stories, we should acknowledge that providers also carry the stories of the women whom they have assisted in giving birth and that these also inform their views and influence the birth culture. Throughout this report, quotes from the birth mothers are included to illustrate the implications these principles or their lack of implementation has had and can have for women. The quotes are italicized. This report does not include an analysis of these birth stories. For a fuller account of their birth stories see, where a summary of the births with some key details of their stories and the range of answers to our questions are summarized.

Roundtable Agenda

The plan for the day was to use the Family-Centred Maternity and Newborn Care guidelines to structure the discussion of understanding the barriers and opportunities to implementing these guidelines. However, as the day proceeded, slight modifications in the agenda were made to allow for more fruitful discussion about how to move forward.

Family-Centred Maternity and Newborn Care in New Brunswick: Barriers and Opportunities

Guided by Health Canada's National Guidelines for Family-Centred Maternity and Newborn Care (FCMNC), the roundtable discussed the state of maternity and newborn care in New Brunswick. It was agreed that the document provides appropriate guidelines for the practice of family-centred care, and that the principles are comprehensive and representative of the needs of childbearing women and their families. An in-depth discussion of the thirteen guiding principles of the FCMNC revealed existing barriers to the practice of family-centred maternity and newborn care, and possible opportunities to enhance the existing system. Below is a summary of the discussion with an incorporation of notes from flipcharts. Each of the thirteen guiding principles is explained briefly, followed by the existing barriers and opportunities for implementing the principles of family-centred maternity and newborn care in New Brunswick. Although all of the

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principles were not discussed by the full roundtable, all participants working in small groups had an opportunity to make notes on flip charts under each principle. The roundtable discussion of the principles ended with a discussion of Principle 4. The rest of the final report is based on notes from the flip charts.

Principle 1: Birth is a celebration – a normal healthy process.
Family-centred maternity and newborn care is based on respect for pregnancy as a state of health and for childbirth as a normal physiological process.

As was made clear in the discussion, the barriers to ensuring that pregnancy and birth are approached as a normal physiological process are all connected to attitudes of the people present -providers, managers and consumers alike. As one participant wrote on the flipchart under this principle: "We celebrate the baby but we've stopped celebrating the 'birth'." Another participant aptly noted that "some people are afraid of birth." Indeed, as it was noted, family centered care is an attitude, that needs to be open to allow space for this kind of principle to come into effect. Therefore, there is a need for further education of everyone involved with pregnancy and birth including care providers and recipients. Sometimes, care providers can get caught up on what can go wrong. As was noted by some participants, however, the pressures on care providers are complex especially when one considers the legal issues. Some participants were wondering about pressures on physicians to be stricter in terms of labour management, about how long a woman can go over her due date, for example.

In the interest of trying to ensure that 'everything goes right,' care providers can forget that more pregnancies are good (meaning low risk) rather than bad. However, the implications of this kind of perspective can influence the approach to pregnancy and birth that results in higher interventions than is medically necessary. As one participant noted, this is especially the case if obstetricians are providing a majority of the care to low-risk women. As one woman said in her birth story:*"I think it is a huge mistake to have Dr.'s who specialize in 'at-risk' pregnancies and deliveries providing care for the majority of pregnant women."*

Other women who shared their birth stories talked about wanting to have a midwife and their frustration at not being able to do so in New Brunswick. As some participants including consumers pointed out, one of the strategies to enhancing attitudes is to have midwives practicing in the province, which would also allow women to give birth at home - 'the most natural place for many women'. As one consumer wrote in her birth story: *"Women need to have a choice of where and with whom she births her baby."* Of course, enabling women to give birth at home is only part of midwifery's commitment to offer a full range of choices for women. As another consumer said: *"Some woman may want to have a midwife in the hospital and that should be an option as well."*

One roundtable participant challenged everyone to think about what having a healthy pregnancy actually means. She argued that the challenge is perhaps in understanding the difference between the nature of birth and the culture of birth. For example, the culture of birth could be about promoting something that some providers feel might ease birth (eg. get rid of the pain) for a woman, instead of enabling the natural process to proceed. Both nature and culture

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can have great variance. One participant noted that we need to be thinking critically about what is normal eg. if the c-section rate were to be over 50% would that become the normal way to give birth? Does normal mean the way the majority give birth or can give birth? What kind of funding or support might allow us to think about what these statistics mean?

Another roundtable participant expressed frustration in trying to go against the current of what is generally accepted as the way a labour should progress ie. dilating 1 cm/hour. She suggested that anyone who doesn't go 'by the book' is considered to have failed to progress. In the words of another consumer: *"Doctors need to show more respect for a woman's inherent ability to birth her own child."*

According to one participant, one barrier is that hospital policies sometimes interfere with supports that could have a beneficial impact such as policies that unreasonably restrict the number of people who can be in the room. There needs to be a close examination of such policies that considers whether such policies -written to ensure safety regulations - have an appropriate evidence-based that outweighs the women's need for such support.

Many participants expressed a dismay with the overwhelmingly negative comments about attitudes and practices that were noted in relation to this principle. One participant pointed out that the practices often vary by region, by institution and by provider and that lots of women in New Brunswick have positive experiences.

Principle 2: Pregnancy and birth are unique for each woman.

The second principle of the family-centred approach to caring for women and families is that care should be adapted care to meet the families' needs, rather than expecting women and families to adapt to institution or provider needs.

Some roundtable participants perceived the system and its providers to be unsupportive of women's cultural or personal choices, which is claimed to be restricted by the general illness approach to birth that seeks to make a diagnosis and apply the 'right' treatment. There is a need, according to some participants, for services in this area to be designed and delivered in ways that acknowledge that birth is not an illness. Part of the discussion pointed to the need to know about the woman's history before she gives birth in order to understand her uniqueness. Some participants pointed to the opportunities that are offered by the midwifery model of care that could contribute to implementing this principle. Specifically, the midwifery model of care emphasizes continuity of carer; that is a small group of midwives builds a relationship with their clients from right after conception, which is important for some women. As one birth mother said of her experience under the care of a midwife: she felt fully understood, supported, and prepared by her midwives. In contrast, other participants noted that women currently receive care from a variety of health care providers throughout their pregnancies, births, and the postpartum period and as a result their care is fragmented. This can prevent a woman and her primary care provider from establishing a relationship. One woman described not wanting to have so many strangers involved in her birth process because it was very stressful and left her feeling like she had nobody to advocate for her as a whole person....*"I truly believe that women – during and after pregnancy – lack the support that they need."*

Other participants pointed to many factors and system structures that hinder a providers' ability to take such an approach: Providers are not often afforded the time to establish these relationships whether that is during prenatal care, during delivery or postpartum. Timely access to providers also figured in the birth stories, as one woman said: *"I recall waiting for up to 2 hours for appointments that would last about 10 minutes. Due to time constraints, I left on 2 occasions without seeing the OB at all."* Time is of course intimately linked with financial resources and that speaks to wages as well as staff numbers. Another barrier that was discussed was whether the facility's policy can allow for the kind of flexibility that would be needed to adapt to women's needs. As one participant noted, recognizing the unique emotional, social, and cultural needs of each woman will ensure that all women receive appropriate care regardless of age, race, ethnicity, socioeconomic status, geographic location, etc.

In some cases, despite the barriers in the current system, women do build good relationship with their family physician. As one consumer wrote: *"I felt very comfortable with my doctor because she had made a point of knowing me personally."*

There was some discussion on the use of birth plans as a way to encourage a woman to express her wants and needs. Some providers encourage women to bring their birth plan and have a discussion early on in labour, and ideally before labour and delivery. Some consumers expressed a concern that a woman's experience differs based on whether she is knowledgeable enough to challenge decisions and advocate for herself and insisting that providers respect her wishes as expressed in her birth plan.

One suggested strategy that might assist to implement this principle is the development of multi-cultural resources that provide patients with information that is culturally appropriate, in their first language and at the right educational level for them to understand their options. The other part of this strategy is the need for provider education such as cultural competency.

Principle 3: The central objective of care for women, babies, and families is to maximize the probability of a healthy woman giving birth to a healthy baby.

There was some discussion of the fact that the maternal re-admission is the second highest in Canada and the need to understand why this is the case because it is one indicator that is suggesting that our mothers are not as healthy as they should be after the birth. Others considered high intervention rates including episiotomy and c-sections as a factor that needs to figure into our assessment of whether we are maximizing the probability of realizing this objective.

Others criticized what is often a narrow definition of health that only focuses on physical health. Healthy needs to be approached broadly as a concept that includes mental, spiritual, as well as physical, sexual, economical etc. One consumer expressed her experience as follows: *"During my whole labour I felt very abandoned by most of the staff. It looked as though as long as my baby and I had heartbeats then nothing else mattered. They left us alone for long periods of time and only seemed to come into the room to check the equipment."*

There was some discussion about the adequacy of postpartum care that is available

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including limited community-based breastfeeding support and inadequate care focused on the mother. One birth mother would like public health nurses to be able to make a home visit for any woman who would like one. One mother said: *"I wanted to breastfeed our son but found the support at the hospital and at home after the fact left a lot to be desired – the first six weeks were painful and worrisome."* Another woman said: *"more supports are needed for new moms to get them through the first weeks at home."* In contrast, all the women who had midwife-assisted births expressed their satisfaction with the care: *"The midwife who had tended to me during my prenatal care, and who had delivered my son, came to my home for follow up visits within 12 hours, 24 hours, and I think another 3 visits over the next week and a half."*

Discussions of the spectrum of care options and support options focused on the lack of emotional and spiritual health of women. There was some discussion about whether this kind of support needed to necessarily come from a professional; formal health care is not what most mothers need at that time. Rather, there is a role for other mothers and other family members. In some ways it is sad that some women are paying for postpartum doulas and others to take care of them in the postpartum period. There is greater expectations on the system to fill in gaps that are increasingly being left because women are more often not living near their families and do not have the same social support network as previous generations. At the same time, we were reminded that the system cannot do everything. One suggested strategy was a more informal network of mothers who want to help new mothers. We need to create an environment where women feel safe to be honest about how they are doing - physically as well as mentally and emotionally. One participant suggested that many women just need someone to talk to that are not some stranger that could take away their baby. As one birth mother said: *"Many mothers do not have the support system I had. I can only imagine the fear and worry they may experience."*

There is some latitude in how best to maximize the probability **of a healthy woman giving birth to a healthy baby**, but one participant noted that this might sometimes not be realized depending on whether the baby is the focus or the mother. In order to ensure that health is maximized, there needs to be more use of evidence to inform decisions. Indeed, many participants suggested that we have to improve what we have before going to the next step and introducing more options. However, in order to be able to do so, there is a need for a provincial reproductive care program that collects the data and helps everyone work together to optimize the resources that are already in the system.

One participant suggested that a key strategy was facilitating women to give birth as close to home as possible recognizing the importance of social support that women need. Some concern was expressed about the closure of maternity units and hospitals in rural communities and the need to recognize that this is not only an issue of access to care, but is an issue that can have broader consequences for the community -something that has been seen in Aboriginal communities. Though of course access and safety are issues that must figure into decisions about which options are offered, as one woman said: *"I was able to reach my rural hospital in time to experience a healthy delivery. Had the travel time to the hospital been a greater distance than it was, things could have turned out very differently."*

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Principle 4: Family-centred maternity and newborn care is based on research evidence. Families should be provided with clear information on the benefits and risks as revealed in the research. One should also be aware of the limitations of evidence-based practice and that in some circumstances, the evidence is unclear.

Some participants raised questions about the need for research. While others pointed out that the problem may be that there is a lack of applied research and that it is not applied effectively or consistently. There was some questioning of who decides what comprises evidence, and how it should apply to clinical practice. Why is it that in some cases, extensive research exists and is ignored? As one participant said, it is well-established in the literature that midwife-assisted home birth is safe, and that the midwifery model of care consistently produces excellent health outcomes for women and babies. Yet midwives in New Brunswick remain unregulated and consequently inaccessible.

Many participants suggested that there is a need for a coordinated collection across the province via a central agency such as reproductive care program. There are a number of databases that exist across the province and some of them interrelate in different regions of the province, but there is no provincial database. Standardized data collection could also allow for the release of data to inform consumers. However, this provincial perinatal program or group could also be charged with gathering the best practices from around the country and the world to ensure that those are guiding practice and enabling providers to provide the best care possible. This could facilitate communication among different provider groups across the province.

Principle 5: Relationships between women, their families, and health care providers are based on mutual respect and trust.

Several women who shared their birth stories, expressed deep regret about the treatment they received. One woman said*: "Throughout my experience, I felt ignored, disrespected, dehumanized, and was completely traumatized as a result. This is not what birth should be."* Another woman said: *"Care is very impersonal. I was not followed by the same professional throughout pregnancy and delivery."* Another birth mother expressed her experience as follows: *"I did not feel as though I was treated as a person, but as a condition."* These are only three women's views, but they are three too many.

Some participants noted that there is a lack of <u>mutual</u> respect and trust in NB between patients and providers as is echoed by the birth mothers. One birth mother wrote that *"the staff showed no respect for our midwife, or our choices. All we wanted was a low technology, quiet, family-oriented birth, and we were made to feel like we were horrible, neglectful parents."* Other participants noted that the problem might not be so much a lack of respect as an unawareness of different expectations. Some participants considered part of the problem to rest with the on-call system where a woman does not know who will attend her birth. As was also noted, providers are largely unsupported in their attempts to make changes such as developing shared care models.

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Principle 6: Women are cared for within the context of their families.
Family-centred care treats the family as a unit. It is up to the woman to define her family and supports; she chooses who is included or excluded.

Some participants questioned whether hospital policies surrounding labour support were appropriate for family-centred care. There was concern that these policies were too restrictive in the limit they place on the number of support people able to be in the room during labour and delivery. There was also a concern raised about the no-rooming in policy when most women do not want to be separated from their families. One of the birth mothers said: *"Mothers should be allowed to have as many support people with her, during labour, as she wishes."*

Some participants believed that being family-centred is not about space, but about attitude. Therefore, while there is a need for hospital renovations, perhaps more energy should be placed on ensuring that there is a consistent understanding of family-centred.

Principle 7: In order to make informed choices, women and their families need knowledge about their care. It is not enough to expect women to bring their "choices" with them – health care providers need to provide time, support, and encouragement for exploration of the various options.

A number of barriers to informed choice were discussed by the roundtable participants. One of the barriers is that prenatal classes may not be equally accessible for all New Brunswick women. Some participants noted that prenatal classes were particularly inaccessible for women in rural and remote areas. One participant suggested the development of a "how-to" resource guide for new parents. Such a resource guide could offer the evidence-based pros and cons on various subjects including the common decisions that women and their families make during pregnancy, birth and the postpartum period. As one birth mother said: *"Women can and should be given informed choices and control over their own care."* However, sometimes the system seems to take the decisions away from the women and their family. There needs to be sufficient time for women to discuss options with their providers. The other principles also lay the foundation for this one to be realized including and especially the need for mutual respect and trust.

Principle 8: Women have autonomy in decision making. Through respect and informed choice, women are empowered to take responsibility. When all relevant information has been made available to women and families for the achievement of their goals, they are guided, not directed, by the professionals they have chosen to share the responsibility for their care. This principle recognizes that women are the primary decision makers about their care and that professional expertise is only one factor figuring in their decisions. The decision-making process needs to be approached from the point where all participants recognize and accept that everyone wants a safe and healthy outcome. As one birth mother implored: *"Listen to women, let them make their own decisions."*

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Some participants noted that the concepts of decision making and informed choice are based on the notion that options exist. In many situations where women and their families are asked to make informed choices, they are not presented with options. Choice of care provider and choice of birthplace are two examples of this phenomenon. Many New Brunswick women would choose midwifery care – an option available in many provinces and territories – if it were available. Others might choose to give birth in a freestanding birth centre, or at home, though no maternity care providers in New Brunswick currently offer these options. One birth mother said: *"I felt my choices were limited to following the physician's recommendations, with little or no consideration given to how I really felt about my birth options."* Another birth mother said: *"Midwives should be available to anyone who wants one, not only those who happen to live near, or can afford one."* Yet another birth mother said: *"Be open-minded to women's choices/requests."*

Some participants suggested that there is inadequate information for patients and that there is limited options for participating in decision-making. One birth mother expressed this concern when she said: *"I felt like they did not honour my wishes and did not properly inform me of what could possibly happen if I did get an epidural."*

There is some need for more communication. One participant suggested that birth plans could play a role in encouraging a group of providers to understand a woman's choices and respect them.

Participants raised concerns that women might be making choices without being fully informed and suggested that decision-making needs to be understood as a process not simply an outcome. Indeed, there is a concern that women and are actively discouraged rather than empowered. One participant suggested that a woman who is assertive has her choices respected. As the participant also pointed out, women shouldn't have to rely on being assertive for choice. Rather, there is a need to recognize that the hospital environment is intimidating and that the doctor-patient relationship is complex. As one birth mother said: *"It is easy to be intimidated as a new mother by doctors, nurses and other health care professionals.*"

Principle 9: Health care providers have a powerful effect on women who are giving birth and their families. This principle asks that health care providers be aware of their power to influence a woman's childbirth experience. It is based on evidence that has shown that satisfaction is more highly associated with the emotional care received during labour than with the birth process itself. Satisfaction is linked to the type of care received and the feelings of personal control and accomplishment. As one birth *""The people supporting a woman during this time in her life need to be positive, have confidence in her, know what she wants and doesn't want and realize that their comments and opinions will have a direct impact on the woman and baby and ultimately her family, society and the world.."* As another birth mother also said: *"His [the obstetrician performing an emergency c-section] confidence, and the confidence of the rest of the OR team reassured me, and I felt great trust in them. As scary an experience as it could have been and was, I felt that I was made as comfortable and secure as possible."*

Participants noted that health care providers do influence the choices that women make

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and have. They reiterated that the system sometimes does not facilitate relationships. For example, fee for service is not conducive to relationships because of the volume of people seen by the provider. There are also not enough providers. A concern was raised that the lack of emotional support leads to issues such as postpartum depression and that there needed to be more in-home post-partum support.

Principle 10: Family-centred care welcomes a variety of health care providers.
This principle recognizes that health care providers include physicians, nurses, midwives, labour companions or doulas, childbirth educators, and various others who help with physical or social needs.

Some participants expressed concerns that some health care providers are not accessible to New Brunswick women. One birth mother said that she felt: *"[Obstetricians] have too many people to see to be able to care enough and give individual attention. Having midwives would hugely lessen the load, and allow the OBs to focus on high risk pregnancies."* As described in other sections of this report, midwives remain unregulated and consequently inaccessible to New Brunswick women. Other health care providers such as doulas and childbirth educators may be available, but only to women who live near them and who can pay for their services. Participants recognized the need for collaboration among a wide variety of health care providers as a way to foster excellence in maternity and newborn care.

Principle 11:Technology is used appropriately in family-centred maternity and newborn care. It is important that technology not be used in place of direct supportive care and observation. The issue of safety should not be viewed as a reason for *unnecessary* intervention.

Some participants expressed concern that technology is often used unquestionably. There is recognition that there is a lot of pressure on providers and patients to use technology. There is also a concern that part of the problem is insufficient staffing; eg. Some nursing staff may feel they have to resort to high tech. monitoring (eg. continuous fetal monitoring) because they do not have the time to provide direct supportive care and observation. A contributing factor to the inappropriate use of technology was also suggested to be the threat of litigation should something go wrong. The result is the overuse of fetal monitors, which can have a cascade affect resulting in the use of other interventions. There is a concern that technology has been erroneously equated with safety. Another barrier is the difficulty in getting funding for low-tech., soft comfort items, eg. chairs, beds, lazy boy with chairs for partners. One participant suggested that there is perhaps a need to "balance high tech with high touch." One birth mother shared her experience as follows: *"My doctor and I decided that I should be induced because I live so far from the hospital. I would have preferred to let nature take its course but I couldn't imagine driving for an hour and a half while in labour."* This raises questions about technology replacing or displacing natural processes in cases where it might not be appropriate, but where the birth mother has also come to fear the unpredictability of labour. This perception might also be contributing factors for decisions to overuse technology and try to have more control over the

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course of the pregnancy, or labour and delivery. Finally, as one consumer wrote in her birth story, it seems clear that: *"More supports are needed for women who want to get through pregnancy and delivery with few interventions."* Another woman described her decision to have a midwife-assisted in home birth as follows: *"I know that birth is a very personal and natural event and was not about to surround myself with machines and strangers."*

Principle 12. Quality of care includes a number of indicators. It is important to monitor not only indicators such as morbidity and mortality, but also women's experience of pregnancy, birth, and postpartum care.

Participants noted that there is a real lack of data about women's experiences of care in New Brunswick. There is little encouragement for women to discuss their experiences. There is also insufficient data on breastfeeding that includes not just how long women breastfeed exclusively, but which women are breastfeeding and which are not. Sufficient data collection is part of being accountable for the quality of care provided to women. Data can be used also to benchmark and set a course for improvements. There is currently only sporadic collection of data and what is needed is a central source for data collection that would include surveys and focus groups with women.

One participant suggested that the indicators should reflect the principles of family-centred care. There is very little transparency around what data is currently collected, why, by whom and how. Most research used to inform practice is quantitative and focused on clinical implications. Family-centred maternity and newborn care must emphasize the importance of qualitative research and consider the psychosocial implications of all practices.

Principle 13. Language is important. Because words can reflect attitudes of respect or disrespect, inclusion or exclusion, and judgment or acceptance, language choices can either ease or impede communication. Such words as "guidelines," working together," and "welcome" convey openness and an appreciation for the position and importance of families. Such words as "policies," "allowed," and "not permitted" suggest that professionals are in authority over women and families.

One participant raised concerns about using language as emotional blackmail when instead of engaging in a discussion about choices, a provider might resort to saying that the "all we really want is a healthy baby." This relays the message that the baby is more important than the mother. There was also a suggestion that providers need to be more aware of the need to clarify medical terminology in recognition of appropriate literacy level. This necessitates spending more time communicating and addressing issues of culturally appropriate language, interpretation and expectations. As one participant said: our language reflects our values. We also need to pay attention to body language, and tone, which also convey strong messages. As one participant noted, it's "not just what you say but how you say it." One birth mother expressed her experience as follows: *"No one spoke to me. They spoke around me and about me, but not to*

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me." Another woman said that during labour complications: *" I became very attuned and alert to reading the faces of staff, to see the real message behind their words - would I be OK, would the baby be OK."*

Conclusion of Roundtable Discussion
At the end of this discussion it was agreed that a concrete strategy that everyone could agree on was working toward the development of a provincial reproductive care program. The group decided to form a working group that would meet again and work toward achieving this goal.

Concluding Thoughts
At the end of the day, participants were asked to share their thoughts about the day, about what they heard and experienced, and whether the day accomplished what they had hoped. The comments from participants at end of day included:

There is more trust now than at the beginning of the day.

I like that it (the roundtable) is so inclusive with people from all over.

This is one of the best focus groups I have been involved in.

There was excellent discussion and I was glad to see we're building towards something positive.

I am happy to be where my passion for child birth began.

I am happy to see the issues getting out there.

We need to tell every woman we know.

I enjoyed the process of going around the table and everyone writing and finding interest in other's opinions.

This is the kind of process that sticks. It is a good start and I hope it continues.

I am leaving with a sense of hope that we can get some choices for women.

I am glad to have been here and I hope to take part in future steps.

I appreciated the differences in age around the table (including a baby or two).

I am very happy to see that everybody has something to share, and to offer.

I am happy to see that mental health is considered important.

I want to reiterate the importance of language. Language is culture and culture is language.

I am glad to have a venue where everyone could have a voice.

I am used to committees where there are no strategies, really enjoyed the progress already and the different people from all backgrounds.

It is great to know that other women are trying to make change happen.

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I think what we are trying to do is actually doable.

I am really excited for the women of tomorrow who will be affected by the actions of today. I am happy that we were such a great group.

While I feel that there was a lot of negativity while doing the groups. It can only get better.

A really important thing is going on today and is going to happen.

I am grateful to be part of this today. I hope that things will continue to go on.

The future belongs to us, and am more positive that things will be improving for women in NB.

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Invitation to a ***New Brunswick Roundtable on Maternity and Newborn Care***

Co-hosted by the Atlantic Centre of Excellence for Women's Health, with Birthing Matters,
in partnership with the Women's Issues Branch, Government of New Brunswick
Friday, November 4, 2005
The Lord Beaverbrook Hotel, 659 Queen Street, Fredericton, NB
Roundtable 10:00am- 4:00 pm, Room: Saint John

You are invited to participate in a roundtable to discuss the status of maternity and newborn care in New Brunswick. In the interest of exchanging ideas and developing strategies for ensuring that women in New Brunswick receive the most optimal primary maternity care possible, this roundtable aims to bring together policy makers, health care providers, programme planners, administrators, community activists, and consumers to discuss what is working and what needs to be improved. The following questions will guide this meeting:

> What maternity and newborn care options are available?
> How has New Brunswick integrated the National Guidelines for Family-Centred and Newborn Care? How could New Brunswick further ensure that care provided during pregnancy, labour and birth, as well as early postpartum care of the mother and infant, adhere more closely to these guidelines?
> What current health human resource issues affect the status of this care in the province? How might we ensure that maternity and newborn care services are provided to women by the most appropriate health care provider? Other regions of Canada have integrated midwives as integral primary maternity caregivers in the health care system. How might the inclusion of midwives and doulas improve the situation?

Please RSVP by **October 12** and when doing so please also indicate whether you have any dietary restrictions and whether you require translation. I welcome your questions and comments and look forward to meeting with you. I can be reached at christine.saulnier@dal.ca or 902-494-7850.

Sincerely,

Christine Saulnier, PhD
Senior Research Officer
Coordinator, Midwifery and Women's Reproductive Health

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Background Source Documents for the Roundtable

Aboriginal Women and Maternity Care

Many aboriginal women still have to leave their communities to give birth. This practice has an isolating and alienating effect for these women when she is transported to a hospital and is without the support of her husband, parents or other relatives. Undoubtedly, bringing the birth back to the community would ensure that the women receive culturally-sensitive care. In addition, empowering the woman and her family to gain control over pregnancy, birth and infant care, as aboriginal midwives would do, would go a long way to strengthening families as well as communities.

Aboriginal Midwifery

Aboriginal midwives in Canada have had a long history of supporting women in their communities through pregnancy, labour, and birth in ways that honoured cultural traditions and beliefs. Their practice predates the midwifery that began with the arrival of settlers. Many events lead to the dissolution of traditional Aboriginal midwifery, including colonialism, the larger culture's adherence to western medicine, residential school systems and policy changes that undermined many Aboriginal health traditions. Currently there is a resurgence in some Aboriginal communities to bring the birthing process back into the community as part of indigenous healing practices. Despite initiatives to return control of childbirth back to Aboriginal women and their communities, however, few Aboriginal midwives have registered with provincial colleges.

Source Document: Carroll D, Benoit C. Aboriginal midwifery in Canada: Blending traditional and modern forms. The Canadian Women's Health Network Magazine 2001 Summer. Excerpt from: Jude Kornelson. Solving the Maternity Care Crisis: Making Way for Midwiferys Contribution Canada's Crisis in Maternity Care. Vancouver: British Columbia Centre of Excellence for Women's Health, 2000. Full report available at: http://www.bccewh.bc.ca/policy_briefs/Midwifery_Brief/midwifbrief%20v4.pdf

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WHAT IS THE DIFERENCE BETWEEN A DOULA AND A MIDWIFE?

The doulas role is to provide physical and emotional support to women and their partners during labor , birth and in the postpartum period. A doula offers information, assistance and advice on topics such as breathing, relaxation, movement and positioning. Perhaps the most crucial role of the doula is to provide continuous emotional reassurance and comfort. Doulas, unlike midwives, do not perform clinical tasks, such as vaginal exams or fetal heart rate monitoring. Doulas do not diagnose medical conditions or give medical advice. From http://www.mymidwife.org/. For more information see: http://www.dona.org/publications/position_paper_birth.php and http://www.dona.org/publications/position_paper_postpartum.php

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Birth Stories

We received 32 (six in French) birth stories. Below are some excerpts in response to the following questions that were asked:

1. What did you experience?

2. Why do you think care was delivered as it was? Identify things that contributed to the care provided.

3. What insights do you have from the experience? What did you or others learn?

4. What can be done so lessons learned benefit future care of mothers and newborns?

Excerpts from the Birth Stories:

1. Answers to the question what did you experience, included:

-A woman whose babies were both born at home in New Brunswick with the assistance of a midwife and assistant and felt it was wonderful.

-One woman had to have an emergency c-section and was overall positive about the experience. She felt she was made as comfortable and secure as possible.

-Another woman had two routine pregnancies with no complications. Both babies were delivered by obstetricians. She expressed finding the VON prenatal course to be invaluable.

-One woman had two birth experiences in NB: one in a small hospital, the other in a large city hospital. Both were natural births with supportive providers and great outcomes. She describes the birth of one of her babies as follows: "*as the child emerged, the student nurse cried and the sun rise was visible out of the window in the labour room. I never got to the delivery room. Baby and I left the hospital an hour after delivery and managed very well."*

-Another woman describes having two vaginal deliveries with epidurals in a local hospital with excellent nursing support.

-One woman describes her "happy delivery" as a short labour that was not too painful and a natural delivery with her family physician.

-Another woman describe the birth of her two children as having involved "unfortunate experiences," with one of the births begin the worst delivery her doctor said he had ever witnessed. She was advised after the second birth to have no more children. She describes the first baby as having shoulder dystocia and the doctor using forceps and an episiotomy that went past the anus. The second delivery resulted in a cervial tear and a her going into shock and losing consciousness.

-Despite the passage of 30 years since the birth of her daughter, a mother recounts her birth experience as one that included stigma experienced because she was a single mother and racial comments about her bi-racial baby. She describes her experience of having a c-section for reasons that she was never clear about as: "altogether what should have been a

happy and supported (if intense) experience was a nightmare - something I had to recover from on my own and with my baby".

-Another woman describes not being able to have a planned home birth because a snowstorm prevented her midwife from assisting. She describes struggling to ensure for her natural birth with staff resenting her requests and decisions.

-One woman describes her daughter being delivered quickly and not being told what was going on with her baby for hours after the birth.

-One woman describes her care as being excellent, despite what she describes as a very difficult labor and delivery.

-One woman contrasts her experience of a midwife-assisted hospital birth in British Columbia to an obstetrician-assisted birth in New Brunswick. She describes the former as having gone smoothly, being completely relaxed and with no interventions. She describes the latter in NB as being without adequate support and feeling panicked many times through labour.

-One woman had a planned c-section for a breech baby and describes not feeling empowered, not being given enough information and not having her concerns recognized and discussed. She describes the care during leading up to the c-section as being excellent, but laments the postpartum care saying she felt the three days in the hospital were not sufficient preparation and were a blur of information, brisk instructions - that left her more exhausted.

-One woman discussed having supportive nurses and family doctor as well as a doula, who all respected her expectations as were laid out in her birth plan - to have a natural child birth.

-Another woman contrasts her births; one born in Ontario with midwives and the other in New Brunswick at the hospital with the assistance of a doula and a wonderful nurse. Both births were vaginal birth; she had an epidural with the second birth. She describes her experience of the first birth with a midwife as: "feeling fully understood, tended to, nurtured, supported, comforted and prepared."

-One woman describes having a c-section, but not understanding why nor feeling that she was involved in the decision-making process. She writes of feeling intensely pressured to have an epidural without any information about possible risks.

-Another woman writes about her second's child birth and describes being pressured to lie down, to have an epidural, to stop trying to labour and to have a c-section. She describes feeling completely ignored, feeling powerless, dehumanized and violated.

-Another woman describes feeling that she needless suffered through pushing with her second child because of cervical scar tissue. She describes not having been told that have precancerous cells removed from her cervix could have this affect.

-A woman describes having her second baby in New Brunswick; feeling pressured to use drugs to start contractions and not being able to bond with her baby afterward.

-A woman describes the birth of her third baby as a perfect, planned, but unassisted (except for the help of her husband) homebirth.

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-Another woman describes feeling like a failure because she had to have an emergency c-section for a baby that was discovered to be breech at 39 weeks - a position that the mother had told the doctors about for quite awhile, but whose opinion was not taken seriously. She describes her stay in the hospital as tiresome -with no privacy, too many disturbances and little support.

-Another woman describes a 63 hour labour and emergency c-section and her biggest regret was that she was not allowed to hold the baby because she needed to be observed.

2. Women identified the following things as contributing to the care provided:

-A midwife who was sensitive and knowledgeable

-That the midwife and woman knew each other very well and were clear about expectations of each other

-Not being on a time schedule for labour progression

-Experienced and confident staff

-Care was impersonal because she was not followed by the same professional throughout pregnancy and delivery.

-Being clear and confident about your expectations and needs

-Having nurses well-trained in breathing techniques to assist with pain control

-Nurses genuinely interested in their jobs

-Caring and attentive family physician

-The short distance to the hospital and an experienced family physician

-Lack of experience of providers resulted in lack of preparation for all possibilities and providers not being proactive, but reactive.

-Wanting to do things differently (having a midwife, planning a home birth) results in confrontations with staff. Feeling like she had been labeled as a trouble maker for scheduling a home birth and refusing tests.

-The amount of time providers take to answer questions and respond to concerns.

-Women who clearly communicated their expectations.

-Having her family doctor deliver the baby.

-Lack of information and involvement in the decision-making about her own care.

-Lack fo respect for the patient’s choices.

-Lack of options (prenatal, during labour and delivery and postpartum) including not having a midwife, not choosing how, where and with whom to give birth and not having adequate support for mental health or breastfeeding postpartum.

-One woman describes not wanting to be in a car or ambulance when in labour for over an hour to reach the nearest hospital.

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-Not having enough services in the local community; having to go elsewhere for prenatal classes and having to travel long distances for appointments. Choosing to be induced to overcome the anxiety about not being able to make it to the hospital in time.

-*Health professionals assuming that every birth and ever woman is the same, that every woman wants to just 'get the baby out'.*

-C-sections have become too common

-Time limits regarding labour progress should not be as inflexible

3. The insights women shared about their experience included:

-A midwife-assisted homebirth made one woman realize that too much money is spent on unnecessary tests, procedures and surgeries in hospitals

-Giving confident and competent care is the priority.

-The importance of body language

-Learned that more supports were needed for women who want to get through pregnancy and delivery with few interventions and more supports are needed for new moms to get through the first weeks at home.

-Breastfeeding needs to be supported more effectively.

-The importance of a mother's attitude about natural birth.

-The importance of not taking rural hospitals for granted. That shutting down these hospitals will "*cause a great deal of worry and grief for expectant mothers and their families"*.

-The need for more information to ensure that women are prepared for the consequences that can occur with complications.

-Health professionals need to "*be sensitized to the rights of the mother, whose body, baby, and experience is at the centre of the drama of birth"*.

-Women need to speak up more and make their wishes known instead of letting staff make all the decisions.

-Current system is very disempowering; it does not build confidence in women's ability to give birth to a healthy baby and parent that child.

-How much support (and education and information) is needed especially for the first pregnancy and birth.

-The importance of home visits for postpartum care that includes breastfeeding support.

-If a woman is able to make an informed choice and feels in control, involved in the decision-making, she will have a more positive experience.

-That you have to advocate for yourself and ask many, many questions.

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4. Lessons they learned that could benefit the future care of mothers and newborns included:

-Midwifery would be an essential service that is available free to women in New Brunswick.

-We need to foster discussion about birthing experiences so that young women hear a variety of experiences.

-Birthing classes need to be focused more on birthing techniques, empowerment and choice.

-More education is needed for health care providers regarding natural management.

-Keep rural hospitals up and running with surgery and obstetrics

-There is an unknown element to all medical procedures, but that knowledge, conversation and instruction can certainly prepare individuals to be better able to deal with situations as they arise.

-There is a need for sensitivity training around 'difference' including understanding marital status, ethnic/religious needs and wishes, racial issues, parental custody issues, etc.

-Women need to be clear about how they want things to proceed and health care providers need to communicate and ensure that mothers are provided with full information about what is going on and why.

-Women need to be empowered to make choices, and be involved in decisions.

-Unless information is provided at the hospital about postpartum depression a woman can find herself without the resources to recognize what is happening once she leaves the hospital.

-There needs to be more dialogue among health care providers.

-There needs to be mutual respect and trust between women and professionals

-Women must be viewed as primary decision-makers in their own care.

-Health care providers must strive to ensure that mom and baby get to bond as soon as possible and that this be the foremost priority.

Francais:

1. Quelques details du soins de maternite:

-Une femme decrit avoir une cesarienne d'urgence avec des professionels tres connaissant et tendres

-Parle d'avoir accoucher ces deux enfants dans une hopitale locale et eu d'excellent soins.

-Une raconte d'une tres bonne experience sauf avec l'allaitement

-Decret son experience comme etant formidable

-Decrit son experience comme ayant tres being passe pour son deuxieme enfant

2. Les choses qui ont contribues au livraison des soins:

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-Le personnel tres connaissant qui l'ont donne beaucoup d'appui durant l'accouchement et avec l'allaitement.

-D'avoir l'encouragement et soins d'une doula l'a permit de rester plus calm lors de son travail

-Le personnel sont debordes/insuffisant

-Pas la premiere acchouchment

3. Apprentisage des experiences:

-Qu'on peut faire confiance au medicin et infirmieres

-Le soutein moral -"*je me sentais pas comme un numero mais entourer de gentillesse et de comprehension.*

-L'attitude des gens qui l'entourent est tres importante

-Que les femme ont besoin d'une voix (une avocate) pour les supporter dans leurs desirs

4. Comment ameliorer l'experience des futures meres et nouveaux-nes:

-Les accomodations (Pas assez de chambres prives; pas d'accomodations adequates pour les conjoints) et pas assez comfortable et humain.

-*Que donner la vie est le plus beau cadeau que l'on puisse s'offrir*

-Fournier beaucoup de support aux nouvelles mamans

-Plus de preventions a propos de depression post-partum

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